FOR OFFICE USE ONLY
License # _____
Date Issued: _____
Fee Submitted:

Application for an Arkansas Supplier of Medical Equipment, Legend Devices and/or Medical Gas License

PART I: GENERAL INFORMATION					
1.	*Business Name*				
	dba or name that will appear on your permit if different from Business Name above				
2.	*Physical Address*				
	Street				
	City				
	State		*Zip*		
3.	*Mailing Address (Complete this section ONLY if different from the physical address above.)*				
	Street or PO Box				
	City				
	State		*Zip*		
4.	*Telephone Number*		*Fax Number*		
5.	*Website*				
6.	*Type of Operation (check all that apply)*	___ Medical Equipment ___ Legend Devices ___ Medical Gas			
7.	*Are you licensed by the FDA?* [ ] *Yes* [ ] *No* *If **Yes**, FDA License #*				
8.	*Is this business located in a state other than Arkansas?* [ ] *Yes* [ ] *No*				
9.	*Person with whom the Arkansas State Board of Pharmacy may communicate regarding this application:*				
	Name		*Position*		
	Telephone		*Cell Phone*		
	Email				

10.	*How long has the applicant been engaged in the distribution of medical equipment, legend devices or medical gas?*	____No. of years
11.	*Has the applicant ever been licensed in Arkansas?*	[ ] Yes [ ] No
12	*Is this application made as a result of a change of ownership?* *If **Yes**, what is the name of the facility licensed by the Arkansas Board of Pharmacy?*_____ *What is the license number?*_____ *What is the expected closing date of the sale?*_____ *Who was the previous owner?* _____	[ ] Yes [ ] No
13.	*Does this business conduct operations at more than one location that distributes medical equipment, legend devices, or medical gas into Arkansas?*	[ ] Yes [ ] No
14.	*If **Yes**, are all facilities licensed in Arkansas?*	[ ] Yes [ ] No

15.	*Does the applicant distribute medical gas only?*	[ ] Yes [ ] No
16.	*Does the applicant have a retail pharmacy license?*	[ ] Yes [ ] No
17.	*Please provide a general description of the products and operations of the applicant related to the wholesale distribution of legend drugs. You may attach a separate sheet if necessary.*	

PART II: Applicant History

Please answer each of the following questions by putting a check (√) in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit. The affidavit should include all relevant dates, and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action. NOTE: If you answer "Yes" to any of the questions below and you have already submitted a detailed affidavit to the Arkansas State Board of Pharmacy explaining your response you need not submit another detailed affidavit. Please note the date of your previous submission next to the applicable question(s).

18.	*Has the applicant ever been convicted of a felony or any crime involving controlled substances or the distribution of medical equipment, legend devices or medical gas?*	[ ] Yes [ ] No
19	*Is the applicant currently under investigation in any state in which it is licensed?*	[ ] Yes [ ] No
20.	*Has the registration or permit of the applicant ever been revoked, suspended or surrendered?*	[ ] Yes [ ] No
21.	*Have any of the applicant owners, officers, directors, or stockholders ever been convicted of a felony or crime involving controlled substances or the distribution of medical equipment, legend devices or medical gas? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	[ ] Yes [ ] No
22.	*Has any sanction or disciplinary action been taken regarding any license, permit or registration issued to the applicant, officers, directors, partners or stockholders involving the distribution of medical equipment, legend devices or medical gas? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	[ ] Yes [ ] No
23.	*Are there any charges pending against the applicant, officers, directors, partners or stockholders involving the distribution of medical equipment, legend devices or medical gas? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	[ ] Yes [ ] No

PART III: Business Ownership

24. *Business Name*: _____

Select the appropriate form of ownership from the choices below, and then go to the next appropriate section.

___ *Sole Proprietorship (Go to24A)*
___ *Corporation (Go to 24C)*
___ *General Partnership (Go to24B)*
___ *Limited Partnership (Go to 24B)*
___ *LLC (Go to 24C)*
___ *LLP (Go to 24B)*
___ *Other (Please explain)*

Company Name:_____

24A. Please provide the Name, and the Address of the Owner of this Company:

24B. Partnership Name, if different from Applicant name listed in Item 1, page 1.

In the space provided below, please provide the names, addresses and percentage ownership of all partners/members. You may attach a list of partners/members if there is not enough space.

Go to Item **25**.

24C. Corporation Name, if different from Applicant name listed in Item 1, page 1.

_____

[ ] Check if Subchapter S Corporation State of Incorporation_____

Is this corporation publicly traded? Yes [ ] No [ ]

Is this corporation a wholly owned subsidiary of another company or corporation? Yes [ ] No [ ]

*If **Yes**, what is the name of the parent company?*

*If **No**, please provide the names, addresses and percentage ownership of all of the owners of this corporation. You may use a separate sheet if you need more space.*

Go to Item **25**.

25. *Please provide the names and titles of the officers or directors of this company*

President _____

Vice President _____

Secretary _____

Treasurer _____

Specify additional titles below _____

_____

_____

_____

_____

If you need additional space for the corporate officer list, please attach the list as a separate document.

PART IV: DOCUMENTATION

26. *Attach copies of the following documents to this application, or an explanation of why these documents are not included:*

(A) *If the applicant is not an Arkansas business, a copy of the license/permit issued by the state in which the applicant is located. If you do not have a license in your home state, please provide a statement from your State Board of Pharmacy stating that you are not required to be licensed.*

(B) *If the applicant is not located in Arkansas, a copy of the latest inspection report of the facility issued by the regulatory agency that performs such inspections in the state in which the business is located. If the facility has never been inspected, a statement from the applicant stating that the facility has never been inspected.*

(C) *Copies of all federal licenses or permits.*

(D) *A certificate of insurance for this facility issued by your insurance agent, showing your product liability insurance, or general liability insurance if you do not carry product liability insurance.* ***Do not send a copy of the policy- just the certificate of insurance.***

PART V: APPLICATION FEES

Check **one** of the following options:

[ ] This is a new permit application.
What is the date this application will be submitted to the Arkansas State Board of Pharmacy? Add thirty days.
What is the new date?_____
If this date falls in an even-numbered year (2006,2008 etc.), the fee is $250.00.
If this date falls in an odd-numbered year (2007,2009, etc.), the fee is $375.00.

[ ] This is a change of ownership of a current license holder.
The fee for a change of ownership is $125.00.

PART VI: CERTIFICATIONS **Please read carefully and sign below.**

I swear, or affirm that all statements made herein and on the attached forms are true and correct. All of the provisions of Arkansas laws and regulations related to the distribution of medical equipment, legend devices and medical gas in Arkansas will be faithfully observed during the period any permit issued may be in force and effect.

I swear and affirm that I know where to locate the statutes and regulations related to the distribution of medical equipment, legend devices and medical gas in Arkansas. (They are available online at the Arkansas State Board of Pharmacy website in the Pharmacy Law book section under the Pharmacy Practice Act § 17-92-901 *et seq* and Regulations 08-01-0001 through 08-01-0003.)

I certify that the applicant employs adequate personnel with the education and experience necessary to safely and lawfully engage in the distribution of medical equipment, legend devices or medical gas in Arkansas; meets the standards of practice described in Regulation 08-01-0003; maintains policies and procedures in written format as described in Regulation 08-01-0003; and complies with all applicable federal, state and local laws and regulations. The applicant will notify the Arkansas State Board of Pharmacy if any information contained in this application changes within thirty (30) days of the change.

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge. I authorize the Arkansas State Board of Pharmacy to review files pertaining to this application and related documents, and all law enforcement records, administrative records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization for entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

Signature of Owners/Representative: _____

Print the name of the Owner/Representative: _____

Position :_____ Date:_____

Checks should be made payable to: *Arkansas State Board of Pharmacy.*

Return the completed application and all related documents and fees to: Arkansas State Board of Pharmacy, 101 East Capitol, Suite 218, Little Rock, AR 72201 Website: *http://www.arkansas.gov/asbp* Telephone: 501-682-0190